ANALYSIS OF MEDICAL AND PSYCHOLOGICAL CONDITIONS AFFECTING THE COURSE OF DEPRESSIVE DISORDERS IN INVOLUTIONAL AGE

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Annotation In the study, a decrease in mortality and an increase in life expectancy led to a change in the age structure of the population: the number of elderly and senile persons increased. This caused an absolute increase in the number of all late-age psychoses, but the proportion of age-related psychoses did not increase. It is generally accepted to divide mental diseases of late age into ‘organic’, i.e. arising on the basis of a certain morphological, mainly destructive, process and leading to various forms of dementia, and ‘functional’, i.e. not possessing a similar anatomical substrate, reversible and, as a rule, not leading to gross dementia. However, clinical and morphological studies have shown the closeness, if not all, then part of the so-called involutional psychoses to endogenous ones. In functional processes, there is no persistent organic decrease in the level of mental activity and morphological cerebral changes.

Keywords: depression, suicide, aggressive disorders, suicidal behavior.

Аннотация В исследовании уменьшение смертности, увеличение средней продолжительности жизни привели к изменению возрастной структуры населения: увеличилось число лиц пожилого и старческого возрастов. Этим обусловлен абсолютный рост количества всех психозов позднего возраста, но удельный вес собственно возрастных психозов не увеличился. Общепринято деление психических заболеваний позднего возраста на «органические», т.е. возникающие на основе определенного морфологического, в основном деструктивного, процесса и ведущие к различным формам деменции, и «функциональные», т.е. не обладающие

подобным анатомическим субстратом, обратимые и, как правило, не ведущие к грубому слабоумию. Однако клинические и морфологические исследования показали близость если не всех, то части так называемых инволюционных психозов к эндогенным. При функциональных процессах не наблюдается стойкого органического снижения уровня психической деятельности и морфологические церебральные изменения.

Ключевые слова: депрессия, суицид, агрессивные расстройства, суицидальное поведение.

Аннотация Тадқиқотда ўлимнинг камайиши, ўртача умр кўриш давомийлигининг ошиши аҳолининг ёш таркибини ўзгаришига олиб келди: кекса ва қари ёшдаги шахслар сони кўпайди. Бунга сабаб кечки ёшдаги барча психозлар сонининг мутлоқ кўпайиши, аммо ёш психозларининг улуши ошмаган. Умуман олганда, кечки ёшдаги руҳий касалликларни "органик," яъни маълум бир морфологик, асосан, деструктив жараён асосида юзага келадиган ва деменциянинг турли шаклларига олиб келадиган ва "функционал," яъни шунга ўхшаш анатомик субстратга эга бўлмаган, қайтар ва қоида тариқасида қўпол ақли заифликка олиб келмайдиганларга ажратиш қабул қилинган. Бироқ, клиник ва морфологик текширишлар инволюцион психоз деб аталадиган психозларнинг ҳаммасини бўлмаса ҳам, айримларининг эндоген психозларга яқинлигини кўрсатди. Функционал жараёнларда психик фаолият даражасининг турғун органик пасайиши ва серебрал морфологик ўзгаришлар кузатилмайди.

Калит сўзлар: депрессия, ўз жонига қасд қилиш, агрессив бузилишлар, ўз жонига қасд қилиш хулқи.

Topicality

In order to determine the main predictors of DS development in patients, we conducted a more detailed analysis of a number of factors that could contribute to the development of depressive disorders. In order to clarify the role of both

individual causes and factors and their complexes influencing the development of DS, we analysed the factors contributing to the occurrence of DS in the main and control groups. To identify and study their significance, 2 groups of patients undergoing inpatient treatment for SS were studied. Both groups were identical in age and sex composition. Comparison of group characteristics was performed using the concordance criterion (x2), comparisons of individual features within the group were performed using Student's t test.

Purpose of the study: In the course of the study, the manifestation of the disorders was noted as a developed anxiety-delusional syndrome, which consists of the following symptoms: mood depression, anxiety, agitation, delusions of judgement and guilt, verbal illusions (misperception of the meaning of words).

Materials and methods: in the clinic of the psychoneurological dispensary. The study included 63 patients aged 45 to 65 years with a diagnosis of depressive episode.

When determining the role of hereditary aggravation, the distribution of patients into 4 categories was used: persons with aggravated heredity for psychiatric diseases, persons with aggravated heredity for cardiovascular diseases, persons with aggravated heredity for psychiatric diseases and cardiovascular pathology simultaneously, and persons with unaggravated heredity for these groups of diseases (Table 1).

Table 1

Distribution of patients depending on hereditary aggravation

Hereditary burden	Main group (n=43)		Control group (n=20)	
	Abs.	%	Abs.	%
On mental illnesses	16	37,2**	6	30
On cardiovascular diseases	6	13,9	3	15

Mental and Cardiovascular Diseases	19	44,2*	11	55
Не отягоNot heavier	2	4,7**	0	0
Total	**43**	**100**	**20**	**100**

It is evident that aggravated heredity for cardiovascular diseases does not play a statistically significant role in the occurrence of involutional depression (13.9% in the main group and 15% in the control group). Among the patients in the control group, no cases with an aggravated heredity for mental illness were identified. At the same time, 13.7% of patients in the main group indicated the presence of relatives suffering from any diagnosed and clinically established psychiatric pathology, with an indication of affective disorders.

When interviewing patients in both groups, the presence of some concomitant somatic diseases that could aggravate the course of the disease and contribute to the development of the depressive syndrome was revealed (Table 2).

Table 2

Presence of concomitant somatic pathology

Having a co-morbidity	Main group (n=43)		Control group (n=20)	
	Abs.	%	Abs.	%
Hypertensive disease	21	48,8	12	60*
Obesity	9	20,9*	4	20*
Endocrine diseases (diabetes, thyroid diseases, etc.)	7	16,3	3	15
Kidney diseases	3	6,9	2	10*
Chronic hepatitis	15	34,9*	9	45
Other diseases	12	27,9*	6	30

The main percentage of patients suffered from hypertension (in 48.8% in the main group and 60% in the control group), which is often a comorbid pathology in the involutional period. When assessing the magnitude of the risk of depression, comorbidity with such diseases as obesity, diabetes mellitus, cerebral atherosclerosis and chronic hepatitis deserves special attention. Thus, the number of obese patients in the main group had the same rate in the comparison group (20.9% and 20%, respectively). It is necessary to pay attention to the fact that patients with DM very often noted the presence of chronic hepatitis (34.9% and 45%, respectively). In the above-mentioned diseases, even in the absence of their comorbidity with other pathologies, independent disorders of the affective spectrum often occur, and the transferred vascular pathology further provokes the accumulation and aggravation of depressive symptomatology.

Thus, after the analysis of constitutional-biological factors, we can deduce a number of the following statements:

a) The incidence of postinfarction depression is somewhat higher in individuals with aggravated heredity for psychiatric pathology.

b) Comorbidity of DR and chronic hepatitis, gastrointestinal diseases, obesity increase the risk of depressive disorders after myocardial infarction.

c) An important role in the structure of personal response to the disease has formed anxiety mechanisms, which are significantly reflected in somatised manifestations of anxiety, which undoubtedly worsens the course of the underlying disease.

The study of patients' health-related quality of life, although having some limitations due to the influence of social characteristics, level of education, peculiarities of life organisation, etc., gave the following picture (Table 3).

Table 3.

Quality of life indicators of patients with different forms of DR

Scales	ТД	МД	ИД	АД	ДБИ	Р
ФА	78,6±14,8	41,0±16,7	48,6±22,8	46,0±17,1	71,6±24,8	<0,01
РФ	80,1±27,4	35,3±42,1	39,4±27,4	45,4±42,1	78,4±27,4	0,01
БТ	42,1±13,4	43,3±13,9	40,1±21,4	46,3±13,0	41,1±23,4	0,05
ОЗ	55,8±17,8	41,7±18,0	45,8±15,1	51,7±17,2	46,9±13,3	<0,01
ЖС	61,4±21,1	51,7±18,5	35,3±18,5	34,4±17,1	56,2±12,5	<0,05
СА	43,4±22,3	45,6±25,1	41,4±19,3	44,1±17,3	46,0±17,6	<0,01
РЭ	40,5±37,3	38,3±31,7	39,2±33,4	46,3±38,0	42,7±38,3	<0,05
ПЗ	49,1±18,4	48,7±16,3	47,4±16,0	46,2±15,8	39,9±17,9	<0,01

For each subscale of the questionnaire, the group of patients with clinical variants of DS showed significantly different quality of life indicators. In terms of physical activity, results with a statistical significance of $p<0.001$ were observed in the profile samples. In the patient group, the volume of physical exertion not limited by health status that they could perform was 78.6% of the maximum volume. This indicator was the highest among the examined samples. The following results were obtained with a statistical significance of $p<0.001$. The role of physical problems in limiting the daily activities of patients with DS was 20.1% of the minimum level,

meaning that physical problems restricted patients' daily activities by almost 80%. This was the lowest result among all samples. An interesting pattern was observed regarding the intensity of subjective pain sensations ($p<0.001$). Almost similar results were observed across all patient groups (ranging from 40.1±23.4 to 46.3±21.4). However, the overall health status, which was closely related to the previous indicator, showed a different picture ($p<0.01$). On the vitality scale (vital tone), with a significance level of $p<0.05$, relatively low indicators were noted in the studied patient groups, whose vital tone was only slightly more than a third of the maximum possible level of 100% (when patients felt energetic and full of strength). The social activity indicator of the patient samples was more than 40% (from 40.9% to 46.0%), meaning that the volume of social connections was limited in the examined patients by more than 50% of the maximum possible level ($p<0.01$).

CONCLUSION

Thus, when anxiety and melancholy predominate in the clinical picture of DR, the severity indicators according to the HADS and Beck scales, which were used to identify TDS, are very similar, and it can be concluded that they are equivalent.

Based on the scale results, it can be stated that as the severity of the patient's somatic condition increases, the amount of daily physical activity they are able to perform significantly decreases. As the severity of DR increases against the background of somatic pathology, the limitation of daily activities related to physical and mental health grows, and consequently, physical and mental activity declines. Among the examined patients, the role of physical problems in limiting life activities significantly increases. The mental health indicator is disrupted and changes significantly to an equal degree regardless of the origin of DR. In addition to the decrease in physical activity and disturbances in the psychosocial status of the examined patients, a decrease in social activity was observed, with a reduction in the extent of patients' social connections as their mental status worsened. In addition to the decrease in physical activity and disorders in the psycho-social status of the

examined patients, there was a decrease in social activity, while the volume of social connections of the patients decreased as the mental status worsened.

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